Mokena Urology

New Patient Form

Date:_____

Name:_____

Street Address:_____

City:_____ State:_____ Zip_____

Home Phone:_____ Work Phone:_____

Email Address (if applicable):_____

Social Security:_____

Age:_____ Date of Birth:_____

Marital Status: Single - Married- Domestic Partner - Widowed - Separated - Divorced

Emergency Contact:_____

Phone :_____

Can you receive texts: _____Yes ____No

Can we leave a voicemail message on this line?_____

Employment Information

Occupation:_____

Employer:_____

Employer Address:_____

City:_____ State:_____ Zip Code:_____

Referring Information

How did you hear about us? (check one)

_____Your Doctor Name:_____

_____Friend or Relative

_____From a Current Patient of the Practice

_____Internet Search

_____Sign/drive by

Primary Care Physician

Name:_____

Location:_____

Insurance Information

Primary

Company: _____

Name of Policy Holder/ D.O.B _____

Policy/I.D. Number_____

Group Number _____

Secondary

Company:_____

Name of Policy Holder/D.O.B_____

Policy/I.D. Number_____

Group Number _____

We will file your insurance for the companies with whom we are contracted. You will be responsible for any copayments or deductibles at the time services are rendered. If you have insurance with a company with whom we have no contract, we will file your insurance for any changes over $200.00. You will be responsible for co-payments, deductibles, out of network amounts, or any portion your insurance states you are responsible for. We allow your insurance company 45 days to pay your claim. If we do not receive payment in 45 days, you will receive a bill at that time. For our HMO/PPO patients, if we are contracted with your HMO/PPO, you will not receive a bill until we have heard from your insurance company. If you have any questions regarding your insurance, please ask to speak with our office.

I agree, consent and understand,

Name: _____

Date: _____

Mokena Urology

Patient Intake Information

Name: _____

Reason for Today's Visit: _____

_____

Medical History

Please indicate the year of diagnosis.

High Blood Pressure: _____ Cancer: _____

Heart Attack/Disease _____ Lung Disease: _____

Stroke: _____ Ulcer Disease: _____

Diabetes: _____ Bowel Diseases: _____

Asthma: _____ Kidney Disease: _____

Prostate Disease:_____ Uterine/Ovarian/Cervical: _____

Bladder Conditions:_____ Other: _____

Surgical History

Please indicate the year of procedure.

Appendectomy: _____ Gallbladder: _____

Heart Bypass: _____ Heart Valve Repair/Replacement:_____

Leg/Knee Surgery: _____ Kidney Surgery: _____

Tonsil and/or Adenoids: _____ Pacemaker:_____

Hernia Repair: _____ Bowel Surgery:_____

Cancer Surgery: _____ Hysterectomy:_____

Kidney Stone Surgery: _____ Bladder/prostate surgery:_____

Other: _____

Medications

Name:	Dosage:	How Often Taken:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any over-the-counter medications, herbs, vitamins, etc.?

_____

Do you take Coumadin (warfarin), a blood thinner?_____

Do you take Aspirin, Plavix, Ticlid, or any other non-steroidal, anti-inflammatory medication (like Motrin)?

_____

Social History

Do you smoke cigarettes, cigars, or pipes? Yes/No How Much?_____

Do you use Alcohol of any kind? Yes/No How Much?_____

_____

_____

Do you use illegal drugs of any kind? Yes/No How Much?

_____

_____

_____

Family History

...of Prostate Cancer?	Yes/No
...of Diabetes?	Yes/No
...of Hypertension?	Yes/No
...of Heart Attack?	Yes/No

Review of Symptoms

	Please check if present
Fever, Chills or Weight Loss?	_____
Blurred Vision, or History of Glaucoma?	_____
Headaches, Nasal Discharge, Sore Throat?	_____
Heart Murmurs, Chest Pain, History of Blood Clots, or cold or swollen legs?	_____

Cough, Shortness of Breath, or Wheezing? _____

Nausea, Vomiting, Heartburn, Diarrhea, Hemorrhoids, Black Tarry Stools, or Rectal Bleeding? _____

Neck, Joint or Back Pain? _____

Any new Skin Rashes, Persistent Itching, Or Sores? _____

History of Seizures, Dizziness, Tremors, Or Numbness? _____

History of Depression, Insomnia, Unusual Anxiety/Stress? _____

History of Anemia or Easy Bruising? _____